

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17312										
CERTIFICATE OF DEATH										
17323										
1. DECEASED-NAME (Type or print)		First MARY		Middle ALICE		Last BOWDLE		2a. DATE OF DEATH Month December Day 28 Year 1968		2b. HOUR 4 P.M.
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 3, 1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline Md.				
10. CITY OR TOWN OF DEATH Preston		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Near Smithson		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housework		12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D. #1		
14. FATHER'S NAME First William T. Middle T. Last Blades		15. MOTHER'S MAIDEN NAME First Alice Middle Dukes Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-34-3846B		17. INFORMANT Address Gifford C. Bowdle, Preston, Maryland, RFD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 ? 10 yr
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1961</u> , to <u>Dec 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>H. R. Trapnell</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D.		22e. ADDRESS Federalsburg, Maryland 21632								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 31, 1968		23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		23d. LOCATION (City or Town) (County) (State) Preston, Maryland				
24. FUNERAL DIRECTOR Frampton Funeral Home, Federalsburg, Maryland		25a. REC'D BY REGISTRAR JAN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						



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17313

CERTIFICATE OF DEATH

17324

1. DECEASED-NAME (Type or print) <b>REBECCA</b>			First Middle Last <b>GODWIN</b>			2a. DATE OF DEATH Month <b>DECEMBER</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR <b>4:30 PM</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>JAN. 12 - 1869</b>			6. AGE (In years last birthday) <b>99</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>CAROLINE</b> Md.		
10. CITY OR TOWN OF DEATH <b>GREENSBORO</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CAHALL GUEST HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>XX</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>QUEEN ANNE</b>			13c. CITY OR TOWN <b>BARCLAY</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>XX</b>		
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>STARKEY</b> Last <b>STARKEY</b>			15. MOTHER'S MAIDEN NAME First <b>SARAH</b> Middle <b>EMORY</b> Last <b>EMORY</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO.		
17. INFORMANT <b>MRS. CLARA HOLDEN - CHESTERTOWN MD.</b>			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Renal Disease</b> <b>4130</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>442X</b> <b>Nutritional Anemia</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1</b> , 19 <b>66</b> , to <b>Dec. 27</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec. 27</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles H. Stonesifer, M.D.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>Dec. 28 '68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>						22e. ADDRESS <b>Greensboro, Md. 21639</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>Dec. 30</b>			23c. NAME OF CEMETERY OR CREMATORY <b>TEMPLEVILLE</b>			23d. LOCATION (City or Town) (County) (State) <b>TEMPLEVILLE MD.</b>		
24. FUNERAL DIRECTOR <b>Edgar L. Lane - Church Hill, Md.</b>						25a. REC'D BY REGISTRAR <b>JAN 6 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First MICHAEL		Middle HRYNKO		Last		2a. DATE OF DEATH Month December 3 Day Year 1968		2b. HOUR 3 P. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 22, 1917		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline Md.					
10. CITY OR TOWN OF DEATH Federalsburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Houston Branch Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Houston Branch Road			
14. FATHER'S NAME Stephen		First Middle Last		15. MOTHER'S MAIDEN NAME Julia		First Middle Last		Nester			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give year or dates of service) WW II		16b. SOCIAL SECURITY NO. 220-03-8423		17. INFORMANT Address Nannie M. Hrynko, Federalsburg, Md., RFD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma with generalized</b>											
2001 DUE TO, OR AS A CONSEQUENCE OF <b>metastasis</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2001 <b>Pulmonary tuberculosis, arrested</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19____, to <b>12-3-68</b> , 19____, that (I) (we) last saw the deceased alive on <b>12-3-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Frank M. Anderson</i>		22c. DATE SIGNED <b>12-4-68</b>		22d. PHYSICIAN'S NAME (Type) <b>Frank M. Anderson M.D.</b>							
22e. ADDRESS <b>Federalsburg, Maryland 21632</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE <b>Dec. 6, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Good Counsel</b>		23d. LOCATION (City or Town) (County) (State) <b>Secretary Maryland</b>					
24. FUNERAL DIRECTOR <i>Frank M. Anderson</i>		ADDRESS <b>Frampton Funeral Home, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 16 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION

X

Approved by the Board of Directors

and the

Board of Directors, dated

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-8. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 10 Film 108 12/31/68 kb 17315 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												17326							
1. DECEASED NAME (Type or Print)						2a. DATE KNOWN OF DEATH						2b. HOUR							
First Middle Last SYLVESTER LEWIS						<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> 12/15/68 19						8:40 P M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years and fraction)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR					
MALE		C		1-23-1927		47 YRS		MONTHS DAYS		HOURS MIN		Month 12 Day 15 Year 1968		0:30					
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH							
Md.				U.S.A.								Caroline							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Preston RFD								Laborer				FARM							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md						Caroline						Preston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last													
Sylvester Lewis						Lucy Brown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
yes				1944				261-20-7310				ELMER LEWIS 135 W. Hill St Bldg. Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Complete Exsanguination																			
8147 DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
(b) Loss of blood resulting from rupture of skull & brain																			
8124 DUE TO, OR AS A CONSEQUENCE OF																			
(c) Auto Accident																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
Four multiple injuries 16 fracture right femur both ends																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
						8:20 P.M. 12/16 1968						Hit by 2 Automobiles between Baltimore							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State							
						State Road						RFD Baltimore Tenner road Preston							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
22b. DATE SIGNED																			
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>													
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
Carole E. Plummer M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
						ADDRESS (Street, city, town, or county)													
						1-17/68													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				12/21/68				Mt Calvary				A & Co. Md							
24. FUNERAL DIRECTOR								ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
J. Brown 10826 Montgomery												DEC 23 1968				Charles Judge			

TSX



# FOR STATE HEALTH DEPT.

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17316

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17327

1. DECEASED-NAME (Type or Print) <u>George Washington Murphy</u>			2a. DATE KNOWN OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1968</u>			2b. HOUR OF DEATH M <u>11:30</u> AM		
3. SEX <u>Male</u>	4. RACE <u>Cau.</u>	5. DATE OF BIRTH <u>2-22-15</u>	6. AGE <u>53</u> YRS.	7. IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	8. IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>	2c. DATE PRONOUNCED DEAD Month <u>12</u> Day <u>20</u> Year <u>1968</u>		
7a. BIRTHPLACE (State or foreign country) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Caroline</u>		
10. CITY OR TOWN OF DEATH <u>Ridgely</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>None</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Maintenance</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>State Roads</u>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md/</u>			13b. COUNTY <u>Caroline</u>			13c. CITY OR TOWN <u>Ridgely</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME <u>John Murphy</u>			15. MOTHER'S MAIDEN NAME <u>Iva Clark</u>			13e. STREET AND NUMBER <u>None</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16b. SOCIAL SECURITY NO. <u>220-05-5242</u>			17. INFORMANT <u>Eligabeth Murphy</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Brain Damage</u> <u>8120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of Skull</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Automobile Accident</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>minutes</u>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>8161</u>		
19a. DATE OF OPERATION <u>12/20/68</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Drove car under end of Tractor Trailer</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <u>12/20/68</u> HOUR <u>4:45</u> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Drove car under end of Tractor Trailer</u>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Central Avenue</u>			21f. LOCATION Street or R.F.D. No. City or Town County State <u>Ridgely Maryland Caroline Maryland</u>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Harold B. Plummer</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>12/22/68</u>		
EXAMINER'S NAME (Type) <u>Harold B. Plummer M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county) <u>Preston Caroline</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>12-24-68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		
24. FUNERAL DIRECTOR <u>J. E. Goulson</u>			ADDRESS <u>Greensboro, Md.</u>			25a. REC'D BY REGISTRAR <u>DEC 27 1968</u>		
						25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

1981

1981

INTERNAL EXAMINER'S CERTIFICATE OF VALUE

TOP SECRET

DEC 31 1981

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17317 CERTIFICATE OF DEATH 17328										
1. DECEASED-NAME (Type or print)		First GOOTEE		Middle STEVENS		Last NEAL		2a. DATE OF DEATH Month Day Year December 3 1968		2b. HOUR 9 P.M.
3. SEX Male	4. RACE White		5. DATE OF BIRTH September 12, 1878		6. AGE (In years last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline Md.				
10. CITY OR TOWN OF DEATH Federalsburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 320 Maple Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Electrician		12b. KIND OF BUSINESS OR INDUSTRY Electrical				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 320 Maple Avenue		
14. FATHER'S NAME First Middle Last Frank Neal		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Liden								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <input checked="" type="checkbox"/> No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 214-30-8675		17. INFORMANT Address Mrs. Olive Andrew, Federalsburg, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u>										2 weeks
4120 Conditions, if any, which gave rise to immediate cause (a) } stating the underlying cause last. (b) <u>Hypertensive cardio-vascular disease</u>										10 years
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
443X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>8-25-65</u> , 19 <u>  </u> , to <u>12-3-68</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>12-3-68</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 		22c. DATE SIGNED 12-4-68		22d. PHYSICIAN'S NAME (Type) Frank M. Anderson M.D.						
22e. ADDRESS Federalsburg, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland				
24. FUNERAL DIRECTOR Frank M. Anderson		25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE 						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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VR A15  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
MARY AGNES NEWCOMB					OCT 8 1968		M		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F	W	SEPT 25, 1893			75 YRS.	MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		9. COUNTY OF DEATH					
MD	USA	NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		CAROLINE		Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
DENTON				at home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
MD	CAROLINE	DENTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
ALEXANDER			FITZHUGH	CATHERINE				WILSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO				Mrs. Fred Brown		Denton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION								17 min	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) ANTERIOR WALL HEART DISEASE									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
42									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M.							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County
While <input type="checkbox"/> Not while <input type="checkbox"/>									
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 12/14/66, 19__, to 10/4/68, 19__, that (I) (we) last saw the deceased alive on 10/4/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED	
Philip P. Felipe MD								12/11/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Philip P. Felipe MD		Denton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Dec. 11, 1968		DORCHESTER MEM.		CAMBRIDGE DOR.		MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
CHARLES V. MOORE		DENTON		DEC 13 1968		Charles Judge			

MEDICAL CERTIFICATION

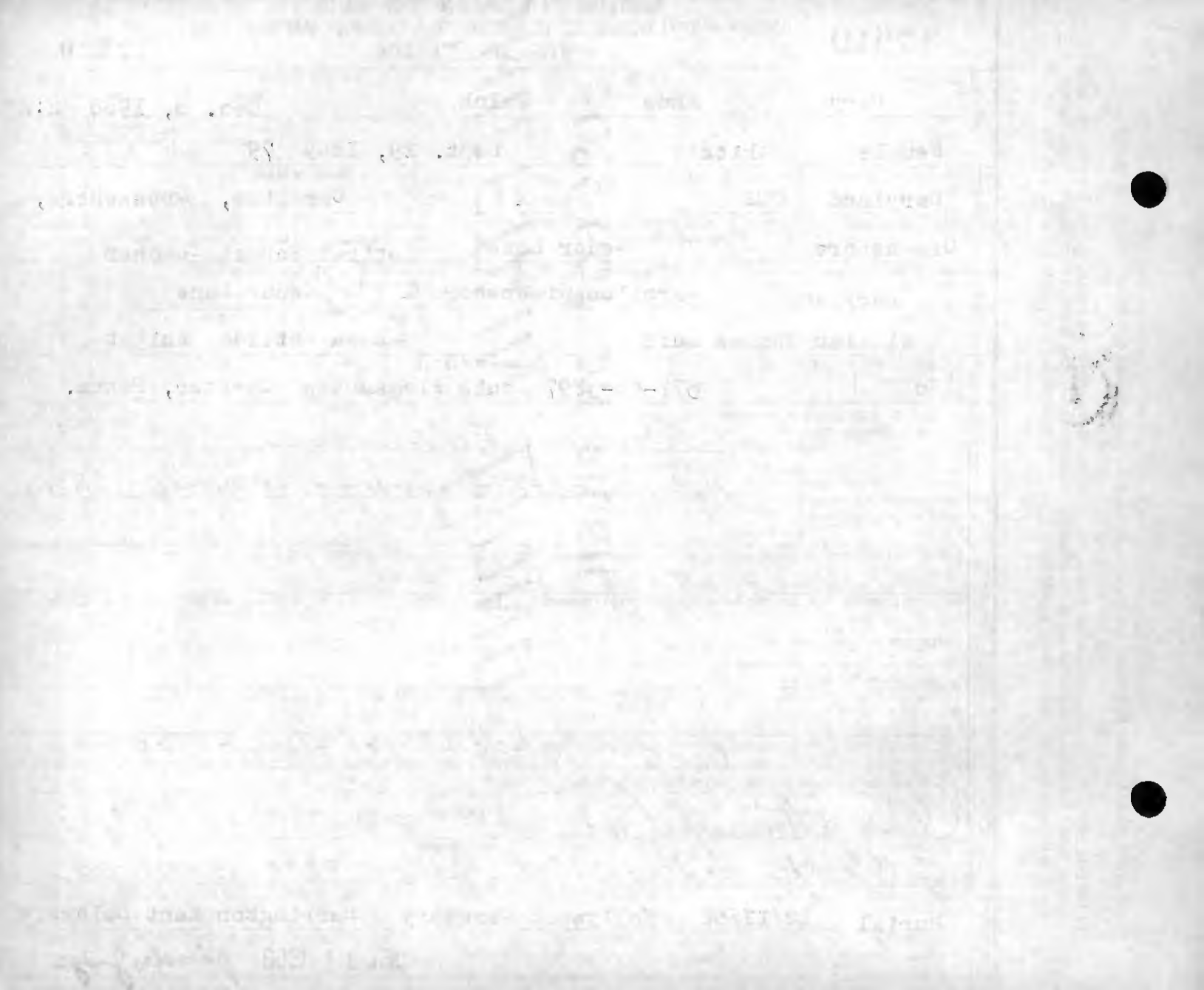




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17319		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17330	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <b>Mary Anna Welch</b>			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>8</b> Year <b>1968</b>		2b. HOUR <b>2:AM</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 29, 1889</b>		6. AGE (In years last birthday) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Caroline, Greensboro, Md.</b>				
10. CITY OR TOWN OF DEATH <b>Greensboro</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cedar Lane</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE <b>Maryland</b>	13b. COUNTY <b>Caroline</b>	13c. CITY OR TOWN <b>Greensboro</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Cedar Lane</b>			
14. FATHER'S NAME First Middle Last <b>William Thomas Luff</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Rosa Matilda Knight</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-48-3297</b>		17. INFORMANT <b>Son</b> Address <b>Louis Pleasanton Chester, Penna.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC CV DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>38 d</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201 DIAPHRAGMATIC HERNIA.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 1, 1968</b> , to <b>DEC 8, 1968</b> , that (I) (we) last saw the deceased alive on <b>DEC 8, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles H. Stonesifer</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/9/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>CHARLES H. STONESIFER</b>				22e. ADDRESS <b>GREENSBORO, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/11/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hollywood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Harrington Kent Delaware</b>	
24. FUNERAL DIRECTOR <b>James Thompson Jr. Federalburg, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
17320											
17331											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR P. M.	
MILTON LEE WILLIS								December 25 1968		8:30 P.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		September 10, 1898		70 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Caroline Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Federalsburg		RFD - Laurel Grove Road		Electrical Contractor		Electrical					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Caroline		Federalsburg				RFD - Laurel Grove Road			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
James S. Willis								Mary Shufelt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO						Ethel E. Willis, Federalsburg, Maryland, RFD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured myocardic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary insufficiency</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4109										0	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										6 weeks	
4201										8 yrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>6-17-60</u> , 19 <u>60</u> , to <u>12-23-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)					
		1-3-69				H. R. Trapenll, M.D.					
22e. ADDRESS		22f. ADDRESS									
Federalsburg, Maryland 21632											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Dec. 29, 1968		Hill Crest Cemetery		Federalsburg, Maryland					
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Frampton Funeral Home		Frampton Funeral Home, Federalsburg, Maryland		DATE JAN 13 1969							

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